DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Resource Based Relative Value Scale (RBRVS) Users:
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Ophthalmologists
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Nurse Anesthetists
Physicians
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For Information Call:
1-800-562-6188

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

Subject: **Physician-Related Services - Clarification of Billing Procedures for Maternity Services**

The purpose of this memorandum is to clarify the Medical Assistance Administration's (MAA) new billing guidelines for maternity services that were issued to address the elimination of state-unique maternity codes.

Coding for Maternity Services

Confirmation of Pregnancy

If a client presents signs or symptoms of pregnancy and the purpose of the client's visit is to confirm the pregnancy, you may bill this visit using the appropriate level of CPT™ Evaluation and Management (E&M) code, assuming that the OB record is not initiated. If the OB record is initiated at this visit, then the visit is considered part of the global OB package and you must not bill this visit separately.

If the pregnancy has been confirmed by some other source and the provider wants to do his/her own confirmation, then the provider may bill the appropriate level of CPT E&M, assuming that the OB record has not been initiated. If the OB record is initiated at this visit, the visit is considered part of the global OB package and must not be billed separately.

Bill using the diagnosis code(s) for the signs and/or symptoms the client is having [e.g. suppressed menstruation (diagnosis code 626.8)] if the purpose of the client's visit is to confirm the pregnancy and the OB record is not initiated. If you confirm the client's pregnancy, do not bill the pregnancy code for this visit, unless the OB record has been initiated. If the OB record is initiated at this visit, the visit is considered part of the global OB package.

Prenatal Assessment

MAA will reimburse providers for one prenatal assessment per provider, per client, per pregnancy. The prenatal assessment covers a thorough, face-to-face visit in which the provider (or other member of the provider's staff):

- Identifies risk factors the client may have;
- Assesses the client's need for additional maternity-related resources; and
- Refers the client for additional services, etc.

You may bill a prenatal assessment on the same day as the E&M visit confirming the pregnancy, or on the same day as the first regularly scheduled antepartum visit, as long as you clearly identify the two separate services in the client's medical record.

Bill the prenatal assessment using HCPCS code T1001 with modifier TH.

Coding for Global Maternity Services

☞ **Note:** If you provide all of the client's antepartum care, perform the delivery, and provide the postpartum care, **you must bill using CPT code 59400, 59510, 59610, or 59618** to report the total global OB package.

When a client transfers to your practice late in the pregnancy…

- If the client has had antepartum care elsewhere, bill the antepartum care, delivery, and postpartum care separately.

  The provider that had been providing the antepartum care bills for the services that he/she performed. Therefore, do not bill the global OB package.

-OR-

- If the client did not receive any antepartum care prior to coming to your office, bill the global OB package.

  In this case, you may actually perform all of the components of the global OB package in a short time. MAA does not require you to perform a specific number of antepartum visits in order to bill for the global OB package.

Coding for Antepartum Care Only

Per CPT guidelines, MAA considers routine antepartum care for a normal, uncomplicated pregnancy to consist of:

- Monthly visits up to 28 weeks gestation;
- Biweekly visits to 36 weeks gestation; and
- Weekly visits until delivery.

If your client moves to another provider (not associated with your practice), moves out of state prior to delivery, or loses the pregnancy…

Only those services provided to these clients are billed to MAA.

- If the client had a **total** of one to three antepartum visits, bill the appropriate level of E&M service with modifier TH for each visit, with the date of service the visit occurred and the appropriate diagnosis. When using CPT E&M codes to bill antepartum care, payment is limited to the established patient codes (CPT 99211-99215 with modifier TH); MAA considers the prenatal assessment to be the first visit with the provider's practice, even if the prenatal assessment is done on the same day as the first antepartum visit.

☞ **Note**: MAA requires modifier TH to be included **on all maternity-related claims billed with CPT E&M codes, regardless of whether the pregnancy is considered normal or high-risk**.

Modifier TH: Obstetrical treatment/service, prenatal or postpartum

- If the client had a **total** of four to six antepartum visits, bill using **CPT code 59425** with a "1" in the units box. Bill MAA using the date of the last antepartum visit in the "to and from" fields.

- If the client had a **total** of seven or more antepartum visits, bill using **CPT code 59426** with a "1" in the units box. Bill MAA using the date of the last antepartum visit in the "to and from" fields.

When billing for antepartum care, **do not bill** using CPT E&M codes for the first three visits, then CPT code 59425 for visits four through six, and then CPT code 59426 for visits seven and on. These CPT codes are used to bill only the **total** number of times you saw the client for all antepartum care during her pregnancy, and **may not** be billed in combination with each other during the entire pregnancy period.

Do not bill MAA for antepartum care until all antepartum services are complete.

If your client changes insurance during her pregnancy…

Often, a client will be fee-for-service at the beginning of her pregnancy, and then be enrolled in a MAA-contracted managed care plan for the remainder of her pregnancy. MAA is responsible for reimbursing only those services provided to the client while she is on fee-for-service. The plan reimburses for services provided after the client is enrolled with the plan.

When a client changes from one plan to another, bill those services that were provided while she was enrolled with the original plan to the original carrier, and those services that were provided under the new coverage to the new plan. You must "unbundled" the services and bill the antepartum visits, delivery, and postpartum care separately.

Additional Monitoring for High-Risk Conditions

When providing additional monitoring for high-risk conditions in excess of the CPT guidelines for normal antepartum visits, bill MAA using CPT E&M **codes 99211-99215 with modifier TH.** The office visits may be billed in addition to the global fee **only after** exceeding the CPT guidelines for normal antepartum care.

A condition that is classifiable as high-risk **alone** does not entitle the provider to additional payment. Per CPT guidelines, it must be medically necessary to see the client more often than what is considered routine antepartum care in order to qualify for additional payments. The additional payments are intended to cover additional costs incurred by the provider as a result of more frequent visits. For example:

> Client A is scheduled to see her provider for her antepartum visits on January 4, February 5, March 3, and April 7. The client attends her January and February visits, as scheduled. However, during her scheduled February visit, the provider discovers the client's blood pressure is slightly high and wants her to come in on February 12 to be checked again. At the February 12 visit, the provider discovers her blood pressure is still slightly high and asks to see her again on February 18. The February 12 and February 18 visits are outside the regularly scheduled antepartum visits, and outside the CPT guidelines for routine antepartum care since she is being seen more often than once per month. The February 12 and February 18 visits may be billed separately from the global antepartum visits using the appropriate CPT E&M codes with the TH modifier, and the diagnosis must represent the medical necessity for billing additional visits. **A normal pregnancy diagnosis will be denied outside of the global antepartum care**. It is not necessary to wait until all services included in the routine antepartum care are performed to bill the extra visits, as long as the extra visits are outside the regularly scheduled visits.

Labor Management

Providers may bill for labor management **only** when another provider performs the delivery. If you performed all of the client's antepartum care, admitted the client during labor, delivered the baby, and performed the postpartum care, **do not** bill MAA for the hospital admission or for labor management. These services are included in the global OB package.

If, however, you performed all of the client's antepartum care, admitted the client during labor, but another provider (outside of your office) takes over delivery, you must "unbundle" the global OB package and bill separately for antepartum care, the hospital admission, and the time spent managing the client's labor.

To bill for labor management in the situation described above, bill MAA for one of the hospital admission CPT codes 99221-99223 with modifier TH. In addition to the hospital admission, MAA will reimburse providers for up to three hours of labor management using the prolonged services codes. Reimbursement for prolonged services is limited to three hours per client, per pregnancy, regardless of the number of calendar days a client is in labor, or the number of providers who provide labor management. **Labor management may not be billed by the delivering provider, or by any provider within the delivering provider's group practice**.

Correction: In Numbered Memorandum 03-34 MAA, page 12, in the crosswalk grid for labor management, MAA **mistakenly listed hospital consultation CPT codes 99251-99263** as required for reporting labor management. **The correct codes are the hospital admission CPT codes 99221-99223 with modifier TH**.

Billing for Maternity Services Before and After July 1, 2003

If you began seeing the client for her pregnancy prior to July 1, 2003, and had already billed MAA for antepartum services using the old state-unique codes, MAA will make a payment adjustment to compensate for any reimbursement already received.

To bill for antepartum services for this client for dates of service on and after July 1, 2003, bill MAA for the antepartum care using the appropriate CPT code that represents the total number of times you saw the client for antepartum care (including those dates of service prior to July 1, 2003). **Use the last date of service in the "To" and "From" fields of the claim form to report the antepartum care**. MAA will make a payment adjustment to compensate for reimbursement received for antepartum care billed using the old state-unique codes.

For example, you saw Client A the following times for pregnancy care:

Date of Service	Service	Billed as	Reimbursement
April 5, 2003	Prenatal Assessment	5930M	$50.00
April 12, 2003	Monthly antepartum visit	5951M	$74.31
May 14, 2003	Monthly antepartum visit	5951M	$74.31
June 12, 2003	Monthly antepartum visit	5951M	$74.31
July 11, 2003	Monthly antepartum visit	59426 - 14 visits total (count the total number of times you saw the client for antepartum care, including prior to 7/1/03)	59426 = $797.37 Less reimbursement already received for antepartum care using state-unique codes billed prior to 7/1/03 = $222.93 $797.37 - $222.93 = $574.44 additional for antepartum care
August 14, 2003	Monthly antepartum visit		
September 11, 2003	Monthly antepartum visit		
October 7, 2003	Biweekly antepartum visit		
October 21, 2003	Biweekly antepartum visit		
November 5, 2003	Biweekly antepartum visit		
November 19, 2003	Biweekly antepartum visit		
November 30, 2003	Weekly antepartum visit		
December 7, 2003	Weekly antepartum visit		
December 14, 2003	Weekly antepartum visit		
December 28, 2003	Weekly antepartum visit		
January 1, 2004	Delivery	59410	$1,060.42
February 21, 2004	Postpartum check		

Note: If you have not yet billed for antepartum services rendered prior to July 1, 2003, then bill using the appropriate antepartum procedure code representing the total number of visits you saw the client for antepartum care.

For your convenience, you will find a table summarizing **Billing MAA for Maternity Services** attached to this memorandum.

To obtain this numbered memorandum electronically, go to MAA's website at http://maa.dshs.wa.gov (click on the Provider Publications/Fee Schedules link).

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Billing MAA for Maternity Services
In a Hospital Setting

Normal Antepartum Care

Service	Procedure Code/ Modifier	Summary of Description	Limits
Prenatal assessment	T1001 TH	Nursing assessment, w/obstetrical service modifier	Limited to one unit per client, per pregnancy, per provider. Must use modifier TH to be reimbursed.
Antepartum care (bill **only one** of these codes to represent the total number of times you saw the client for antepartum care)	99211-99215 TH **or**	Office visits, antepartum care 1-3 visits only, w/obstetrical service modifier	Limited to 3 units when used for routine antepartum care. Must use modifier TH to be reimbursed.
	59425 **or**	Antepartum care, 4-6 visits	Limited to one unit per client, per pregnancy, per provider.
	59426	Antepartum care, 7+ visits	Limited to one unit per client, per pregnancy, per provider.

Additional Monitoring for High-Risk Conditions

Service	Procedure Code/ Modifier	Summary of Description	Limits
Additional visits for antepartum care due to high-risk conditions	99211-99215 TH	Office visits w/obstetrical services modifier	May **not** be billed with a normal pregnancy diagnosis (V22.0-V22.2); diagnosis must detail need for additional visits.

Prenatal/Postpartum Care and Assist at C-Section

Unbundle the global maternity codes and bill for those services provided. Bill the "assist at C-section" using CPT code 59514 with modifier 80.

Labor Management

When billing MAA for prolonged services, use the appropriate prolonged services procedure code on the same claim form as the CPT E&M code with modifier TH and one of the diagnoses listed below on each detail line of the claim form. Payment for prolonged services is **limited to a maximum of three hours per client, per pregnancy**, regardless of the number of calendar days a client is in labor, or the number of different providers who monitor the client's labor. **MAA does not reimburse the delivering provider, or any provider within the delivering provider's group practice, for labor management**.

Service	Procedure Code/ Modifier	Summary of Description	Limits
Labor Management (may only be billed when another provider takes over and delivers the infant)	99221 - 99223 TH	Hospital admit services w/obstetrical services modifier; attended labor inpatient hospital setting	Diagnoses 640–674.9; must have modifier TH to pay; limited to 3 hours per client, per pregnancy; **must not be billed by delivering physician.**
	+99356 TH **Limited to 1 unit**	Prolonged services, inpatient setting, 1st hour	
	+99357 TH **Limited to 4 units**	Prolonged services, inpatient setting, each additional 30 minutes	

High-Risk Delivery Add-On

In addition to the reimbursement amount for the delivery itself, MAA will pay providers a flat fee of $282.81 for the high-risk delivery add-on. Bill MAA using modifier TG with the actual delivery code performed (e.g. 59400 TG or 59409 TG).

Bill only ONE line of service (e.g. 59400 TG) to receive reimbursement for BOTH the delivery and the high-risk add-on. DO NOT bill the delivery code (e.g. 59400) on one line of the claim form and the high-risk add-on (e.g. 59400 TG) on a second line of the claim form.

Service	Procedure Code/ Modifier	Summary of Description	Limits
High-risk delivery	TG added to delivery code	Complex/high level of care	Diagnosis code must demonstrate the medical necessity for high-risk delivery add-on.

☞ **Note:** MAA **will not reimburse** an assistant surgeon or co-surgeon for a high-risk delivery add-on. Reimbursement is limited to one per client, per pregnancy.